

Bureau of Health Care Quality and Compliance

5/14/10 POC
accepted B. Cavanaugh HP&MT
PRINTED: 04/27/2010

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3330SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/15/2010
NAME OF PROVIDER OR SUPPLIER MOUNTAINVIEW CARE CENTER AT BOULDER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 ADAMS BOULEVARD BOULDER CITY, NV 89005		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
Z 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 4/14/10 and finalized on 4/15/10, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing.</p> <p>Complaint #NV00025023 was substantiated with deficiencies cited. (See Tags 300 and 301) Complaint #NV00024599 was unsubstantiated.</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	Z 000	<p><i>This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Mountain View Care Center agrees with the allegations and citations listed on the statement of deficiencies. Mountain View Care Center maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Mountain View Care Center's written credible allegation of compliance.</i></p> <p><i>By submitting this plan of correction, Mountain View Care Center does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Mountain View Care Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.</i></p>		
Z300 SS=E	<p>NAC 449.74491 Prohibited practices</p> <p>1. A facility for skilled nursing shall adopt and carry out written policies and procedures that prohibit:</p> <ul style="list-style-type: none"> a) The mistreatment and neglect of the patients in the facility; b) The verbal, sexual, physical and mental abuse of the patients in the facility; c) Corporal punishment and involuntary seclusion; and 	Z300	<p>Z 300</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>No specific residents were identified as being affected by this deficient practice.</p> <p><i>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</i></p> <p>All residents have the potential to be affected by this deficient practice.</p> <p><i>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</i></p>		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

RECEIVED

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

MAY 07 2010

899

PG4M11

If continuation sheet 1 of 3

BUREAU OF LICENSURE
AND CERTIFICATION
CARSON CITY, NEVADA

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3330SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/15/2010
NAME OF PROVIDER OR SUPPLIER MOUNTAINVIEW CARE CENTER AT BOULDER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 ADAMS BOULEVARD BOULDER CITY, NV 89005		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z300	Continued From page 1 d) The misappropriation of the property of the patients in the facility. This Regulation is not met as evidenced by: Based on interview, the facility failed to ensure a staff member did not use foul language in the presence of residents. Severity: 2 Scope: 2	Z300	All staff have been reeducated, or are scheduled to be, relative to facility policy regarding what constitutes abuse, proper conduct, language and demeanor when in, or around, the facility. Included in the inservice was the definition of abuse etc. <i>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur i.e. what program will be put into place to monitor the continued effectiveness of the systemic change?</i> Inservicing on resident abuse will be conducted at least on a semi-annual basis. All staff have been requested to "police" each other especially relative to conduct, demeanor and language when in, or around, the facility and to report any incidence to their supervisor. <i>Monitored by:</i> Administrator; All Department Heads <i>Date that the corrective action will be completed:</i> April 30, 2010 Z 301 <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i> No specific residents were identified as being affected by this deficient practice. <i>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</i> All residents have the potential to be affected by this deficient practice. <i>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</i>	
Z301 SS=E	NAC 449.74491 Prohibited practices 2. A facility for skilled nursing shall adopt procedures which ensure that all alleged violations of the policies adopted pursuant to subsection 1 and injuries to patients of unknown origin are reported immediately to the administrator of the facility, to the bureau and to other officials in accordance with state law, and are thoroughly investigated. The procedures must ensure that further violations are prevented while the investigation is being conducted. This Regulation is not met as evidenced by: Based on interview, the facility failed to investigate and implement corrective action based on reports that a staff member used foul language in the presence of residents and failed to report allegations and the results of investigation(s) of verbal abuse to the Bureau. Severity: 2 Scope: 2	Z301		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3330SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/15/2010
NAME OF PROVIDER OR SUPPLIER MOUNTAINVIEW CARE CENTER AT BC			STREET ADDRESS, CITY, STATE, ZIP CODE 601 ADAMS BOULEVARD BOULDER CITY, NV 89005		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
			<p>All staff have been reeducated, or are scheduled to be, relative to facility policy regarding what constitutes abuse, proper conduct, language and demeanor when in, or around, the facility. Included in the inservice was the definition of abuse etc.</p> <p><i>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur i.e. what program will be put into place to monitor the continued effectiveness of the systemic change?</i></p> <p>Inservicing on resident abuse will be conducted at least on a semi-annual basis. All staff have been requested to "police" each other especially relative to conduct, demeanor and language when in, or around, the facility and to report any incidence to their supervisor. .</p> <p><i>Monitored by:</i> Administrator; All Department Heads</p> <p><i>Date that the corrective action will be completed:</i> April 30, 2010</p>		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.